



On Watch, by Jeffrey Manuszak, watercolor on paper, Somalia, 1993.
Art: Courtesy of the Army Art Collection, US Army Center of Military History

Chapter 15

MALINGERING AND FACTITIOUS DISORDERS

SEBASTIAN R. SCHNELLBACHER, DO*^{*}; AND RACHEL SULLIVAN, MD[†]

INTRODUCTION: DECEPTION AS A CLINICAL ISSUE IN PSYCHIATRY

CLINICAL APPROACHES

CLINICAL PITFALLS

DIAGNOSES OF DECEPTION

RED FLAGS OF DECEPTION

CLINICAL MANAGEMENT

DECEPTION AND THE MILITARY

RECENT CASE LAW

SUMMARY

^{*}Chief, Inpatient Psychiatry, Department of Behavioral Health, Madigan Army Medical Center, 9040 Jackson Avenue, Tacoma, Washington 98431-1000

[†]Major, Medical Corps, US Army; Child and Adolescent Psychiatry Fellow, Tripler Army Medical Center, ATTN: MCHK-PS, Room 2B 540, One Jarrett White Road, Tripler Army Medical Center, Hawaii 96859

INTRODUCTION: DECEPTION AS A CLINICAL ISSUE IN PSYCHIATRY

From the physician faced with a sick call from a patient seeking quarters the day before his or her physical fitness test, to the surgeon caring for a soldier who was somehow shot in the foot with his or her own weapon during deployment, deception is a potential problem in any military medical encounter, regardless of medical specialty. This topic can be uncomfortable for healthcare providers in general, and behavioral health providers in particular. Medical training is designed around the collaborative and paternalistic model of the patient seeking care and the physician providing it. The behavioral health setting takes that one step further, with the understanding that not only is the patient openly seeking help, but also that a therapeutic rapport will be a significant aspect of the treatment. A deceiving patient rejects this model, and unless healthcare providers are forensically trained, their education leaves them unprepared.

To make things more complicated, there are many reasons besides malicious or fraudulent intent as to why a person may deceive. Soldiers may deceive to do the following:

- avoid punishment or consequences;
- resolve conflicting expectations (eg, the command may strongly encourage working longer hours, while the family wants the soldier home);
- preserve a sense of autonomy (eg, not disclosing something in a social or work setting that would cause potential difficulty, such as sexual orientation, religion, or chronic illness. This allows the individual to interact in that setting as if the difficult issue did not exist);
- preserve Heinz Kohut's "grandiose self" (This may be seen when someone is not willing to yet accept his or her own limitations because it would challenge the idealized sense of self in such a way as to call into question his or her sense of identity. For example, a mother who denies that she has a depressed child because

she internalizes the diagnosis as a challenge to her belief that she is and must continue to be a perfect mother.)¹;

- remain in a unit or status for which they are no longer physically capable because of injury or illness (pilots and special forces units, in particular);
- meet standards they know they will otherwise fail (eg, a homosexual man who married a woman and had children to meet the social expectations of a soldier before the repeal of "Don't Ask Don't Tell"); or
- myriad other reasons as unique as one's psychological makeup.

Furthermore, those who care for active duty service members are charged with the dual agency of treating not only the soldier's medical issue, but also advocating for the military system (eg, a physician may diagnose a soldier with bipolar disorder, which may disrupt his or her plans for a long-term military career). This dual agency likely increases incidents of deception, and since the medical bias sways toward being the patient's advocate, it can be tempting for physicians to "look the other way" and give their patient the benefit of the doubt in all but the most egregious cases. This temptation to ignore deception is worsened because physicians are not equipped with the resources to verify a patient's history, nor can many psychiatric illnesses be verified in an empirical way.

The goal of this chapter is to explore the issues surrounding deception during patient encounters in the military setting, as well as how these issues have evolved throughout military history. Although they are most often thought of in cases where factitious and malingering diagnoses are being considered, they are by no means limited to such cases. The clinical implications of these issues will be covered as well as some possible strategies for the clinician faced with common clinical dilemmas that arise when patients are deceptive.

CLINICAL APPROACHES

Purely Subjective
(Psychodynamic)

Both Subjective and Objective Focus
(Cognitive behavioral therapy, Socratic questioning)

Purely Objective Focus
(Forensic)

Just like any other psychotherapeutic technique, dealing with deception is a clinical skill that needs to be practiced and honed. Many possible approaches exist, but perhaps the most simple is to consider one's clinical

stance in any given encounter as a spectrum, with the one extreme being a psychodynamic approach with a purely subjective focus, and the other extreme being a forensic provider with a purely objective focus. The

more thoroughly one has considered this spectrum and decided where any given patient encounter should be on it, the less ambiguity and frustration one will feel during the encounter itself, benefitting patient care and avoiding the significant negative countertransference that is often felt by physicians in clinical situations involving deception.

On the purely psychodynamic, psychotherapeutic extreme, one stance maintains that the only important perspective is the patient's subjective experience. This stance is appropriate in a clinical environment where rapport is the most important aspect of the relationship and when deception does not significantly affect therapy or administrative responsibilities. An example is a patient who tells a physician, "I haven't slept more than 2 hours this whole month." Research shows that patients with insomnia often under-perceive the duration of their sleep,² yet in this situation it may be useful to the physician to get the necessary information by obtaining a sleep study, asking for a sleep journal, or focusing more on other complaints, instead of challenging the patient directly. However, this seemingly safe approach has potential pitfalls. In this example, the physician may feel pressure to prescribe medication that may not be necessary, which is not a wholly benign choice. Also, patients may be reluctant to disclose some issues because of shame, guilt, or other reasons that may ultimately hinder their recovery, which is why core tools of psychodynamic therapy include clarification and confrontation.

A more moderate approach would be typified by the stance a therapist takes during some types of manualized psychotherapies, such as cognitive behavioral therapy. In therapies where both behavior and cognition are relevant, the patient's subjective experience is equally important when compared with objective realities and probabilities. The work itself is centered on bridging the gap between the subjective and objective, and the physician's intention is to try to encourage concordance with what is perceived and what is actual or probable. This would be the mean or "middle, moderate choice" between the two extremes in the spectrum proposed above. In this case deception would significantly hinder patient progress because it would cloud the therapist's ability to address the incongruities

between reality and a patient's perception. An example is an anxious patient who refuses to admit or discuss a significant aspect of his or her current situation that is contributing to his or her symptoms. By consciously choosing a moderate stance on the proposed spectrum, a physician would both value the subjective experience of the patient while incorporating a significant amount of probing and questioning, hoping to lead the patient to a more honest and accurate understanding of his or her situation. The biggest pitfall of this approach is striking the appropriate balance between maintaining rapport and truth-seeking. Having patience and going at the individual's pace are paramount.

On the opposite extreme of this spectrum is the forensic approach. A forensic psychiatric interviewer is interested in the subjective experience of the person interviewed, but only insofar as these are necessary data when examining specific factors that are relevant to answering the consulting question: whether or not an individual is competent to stand trial, his or her state of mind during an incident in question, and so forth. But these subjective data, which are not given the same weight as the objective, are treated as merely additional information to create a complete picture that can then be examined and synthesized for legal consultative purposes. Rapport with the individual is less important because this encounter is not meant to be therapeutic. In a true forensic setting this is relatively straightforward, and it is even obligatory to explain to the individual that no confidentiality or patient-physician relationship may be implied by the encounter. However, this approach is very limited outside of that setting. One may feel obligated to confront a patient with the suspicion of deception, especially in a case of obvious malingering, but it may destroy the rapport needed to continue the clinical work initially attempted before deceit was discovered. Additionally, besides making recommendations to command or providing diagnoses in a medical chart, a physician has no power over the legal system and cannot choose to prosecute, even if malingering is suspected or diagnosed. The Uniform Code of Military Justice (UCMJ) has standards and legal protections that do not provide for legal intervention merely because the medical diagnosis is given.

CLINICAL PITFALLS

A significant clinical pitfall that a physician can encounter is forgetting that just because a patient is not telling the truth, it does not mean that he or she is lying. Psychosis, dissociation, brain injury, or another clinical syndrome can leave patients unable to correctly perceive reality (eg, a patient could believe "I

am the prince of Persia" or "My blood cures AIDS"). Another possible cause of inaccuracy is that patients can frequently have misperceptions of reality ("My chain of command is trying to ruin my life") when those perceptions might be different than reality itself ("We had to punish him for going AWOL, but we

think that he has the potential to be a good soldier"). Inaccuracies also occur because patients frequently make mistakes and present information to physicians that are not reflective of reality ("No I have not had any surgeries . . . oh yeah, that's right, I did have my wisdom teeth out last year").

Another significant pitfall that physicians can easily encounter is forgetting that the presence of deception, malingering, or factitious disorder does not exclude the presence of underlying real pathology or distress. An individual charged with a serious crime, for example, could malingering an auditory hallucination that "forced him" to assault others, but still be in significant

underlying distress and have tremendous amounts of depression and anxiety. By only focusing on the inconsistencies in a clinical encounter, physicians can ignore an opportunity to heal their patients, a function that is arguably their primary duty.

The diagnosis of a condition that involves intentional deception should be the clinical exception instead of the rule, and it should never be used as a default. It is extremely important to consider professional burnout if these conditions are considered first or with great frequency. Any diagnoses that involve intentional deception should only be given with careful consideration and collateral information.

DIAGNOSES OF DECEPTION

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is the standard reference for the classification of mental disorders. In this diagnostic reference guide, three primary diagnoses can possibly deal with deception: (1) somatic symptom disorder, (2) factitious disorder, and (3) malingering.

The latest edition, the *DSM-5*, has combined factitious disorder with the previous somatoform disorders into a simplified category of "Somatic Symptom and Related Disorders." Factitious disorder has also been separated into two diagnoses as described below:

Factitious Disorder Imposed on Self (300.19)

- a. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
- b. The individual presents himself or herself to others as ill, impaired, or injured.
- c. The deceptive behavior is evident even in the absence of obvious external rewards.
- d. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.
- e. Specify if single episode or recurrent episodes.

Factitious Disorder Imposed on Another (300.19)

- a. Falsification of physical or psychological signs or symptoms or induction of injury or disease in another, associated with identified deception.
- b. The individual presents another individual (victim) to others as ill, impaired, or injured.
- c. The deceptive behavior is evident even in the absence of obvious external rewards.
- d. The behavior is not better accounted by another mental disorder such as delusional disorder or another psychotic disorder.

Note: The perpetrator, not the victim, receives this diagnosis. The provider should also specify if there is a single episode or recurrent episodes of this condition.³

The *DSM-5* has kept malingering within the section of "Other Conditions That May Be a Focus of Clinical Attention." Its description in this edition is essentially the same as the previous *DSM*, and is as follows:

Malingering (V65.2)

The essential feature of malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. Under some circumstances, malingering may represent adaptive behavior, for example, feigning illness while a captive of the enemy during war-time. Malingering should be strongly suspected if any combination of the following is noted:

1. Medico-legal context of presentation.
2. Marked discrepancy between the individual's claimed stress or disability and the objective findings and observations.
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed regimen.
4. The presence of antisocial personality disorder.³

Both of these diagnoses involve evidence of intentional deception, a characteristic that distinguishes them from other diagnoses such as conversion disorders, where the patients display nonorganic medical symptoms because of an unconscious process. Without evidence of intentional deception, a somatic symptom disorder

where there may be enhanced presentation and treatment seeking of symptoms is more appropriate. The presence of intentional deception also distinguishes factitious disorder and malingering from unintentional

inaccuracies that can be seen in psychotic disorders or dissociative disorders. Factitious disorder is distinguished from malingering in that factitious disorder has no obvious external motivators for the deception to occur.

RED FLAGS OF DECEPTION

Many indicators of possible deception may cause a physician to consider the possibility of somatic symptom disorder, malingering, or factitious disorder. It is easiest to separate these indicators into categories of the style of presentation, internal inconsistencies within patient's history, and external inconsistencies between the patient's history and external sources of information.

The manner a patient provides a history may hint that deception is present. For example, if a patient presents symptoms in a specific clinical order (eg, in the order of the *DSM* diagnosis) or uses clinical words to describe complaints ("I have an exaggerated startle reflex"), it could reflect deception. A physician must be careful because this can also reflect patients who have educated themselves about their condition and who are trying to clearly communicate their concerns. Similarly, if a patient uses exactly the same words or phrases multiple times in a clinical encounter, it may demonstrate some prior rehearsal and possible deception (Patient: "I saw a long knife dripping with blood floating around the room and then it started wildly stabbing people." Therapist: "I'm sorry, I missed what you just said, can you describe that again?" Patient: "I saw a long knife dripping with blood floating around the room and then it started wildly stabbing people."). This example also demonstrates how an overly dramatic presentation or extremely exaggerated symptoms can also be a deception indicator. Sometimes people who are trying to deceive frequently repeat questions or answer straightforward questions very slowly. In a similar way, if a patient is not cooperative with the psychiatric assessment, or suddenly becomes uncooperative after being asked a more detailed question about his or her self-report, it can also raise concerns about the veracity of a patient's self-report. Another indication of potential deception occurs if a patient eagerly or readily brings up potentially distressing experiences or embarrassing symptoms (especially early in an interview). If a patient does not appear to be distressed by his or her psychiatric symptoms or cannot describe coping strategies he or she used to try to mitigate these normally distressing symptoms, it is also may indicate possible malingering or factitious disorder (eg, the patient cannot describe how he or she tries to self-treat when getting the command auditory hallucinations).

The content of a patient's self-report also can be a vital clue. The presence of internal inconsistencies in an individual's self-report can be a flag for intentional deception. An example of this could include a patient who reports being two different places at the same time at different times during the interview. Similar inconsistencies also can occur between multiple interviews over time. An evolving history over multiple interviews also raises suspicion (First interview: "I heard a voice." Second interview: "It was telling me to do bad things." Third interview: "It was a horrible male voice. It kept saying kill them all, kill them all."). Other content in a self-report that can reflect deception includes an individual reporting things that happened during reported amnesia periods or giving clear explanations of what happened when he or she was confused or had an altered mental status.

An important red flag that raises the possibility of deception is if the content of a patient's self-report includes uncommon or atypical psychiatric conditions. In 2001 Rosenhan showed a physician's tendency to blindly accept reported mental health symptoms when he had eight normal patients report atypical auditory hallucinations. All of his subjects were subsequently admitted to a psychiatric hospital and diagnosed with schizophrenia.⁴ To avoid similar errors, it is vital for physicians to understand the typical presentations of various psychiatric conditions. Auditory hallucinations, for example, are typically described as coming from outside of one's head, are heard in both ears, are not constant, and are usually understandable and describable (but psychotic patients can report muffled or unintelligible voices as they resolve after antipsychotic treatment is initiated). Visual hallucinations are typically accompanied by auditory hallucinations, are usually in color, and usually involve normal-sized people and objects. Delusions typically do not have an abrupt onset or termination, and they typically are discovered gradually or slowly in an interview because most individuals do not eagerly call attention to them.^{5,6}

Posttraumatic stress disorder (PTSD) is a diagnosis that is frequently malingered in the civilian environment because all of its diagnostic elements are based on self-report.^{7,8} Like other conditions, knowing the typical and atypical presentation patterns can be helpful in identifying deception. Atypical symptoms of PTSD include an individual readily discussing his

or her traumatic experiences, having PTSD symptoms that do not improve or fluctuate, having the absence of survivor guilt, describing flashbacks that involve only one sensory modality, reporting complete dissociation, having extremely exaggerated symptoms, being selectively able to function in and enjoy recreational activities, and glorifying one's actions during the traumatic event itself.⁸

Inconsistencies between a patient's reported behavioral health symptoms and external sources of information are sometimes the clearest red flags for deception. These inconsistencies can include reported behaviors inconsistent with observed behaviors (eg, an individual who reports consistently intolerable PTSD symptoms and insomnia but does not demonstrate these symptoms over a week long hospitalization; the patient who reports constant auditory or visual hallucinations that does not appear to be reacting to internal stimuli; or the patient who reports extreme psychotic symptoms without evidence of disorganization). Furthermore, the reported symptoms may not be compatible with the overall level of functioning the patient is known to have. Does the person who reports frequent and severe anxiety attacks continue to be social or does he or she stay at home? Does the individual who reports constant and extremely distressing visual hallucinations have any issues driving?

Another source of evidence of external inconsistency can be found in the routine medical workup. Is the patient's report of illicit drug use consistent with the urine drug screen done in the emergency department? Was the individual who denies alcohol use able to walk and talk with a blood alcohol level of 295? Are that individual's liver enzymes elevated with the classic aspartate aminotransferase/alanine aminotransferase (AST:ALT) 2:1 ratio and an elevated gamma-glutamyl transpeptidase (GGT)? Are the depakote levels decreased in an individual who reports that he or she is compliant and takes his or her medications daily? Do the pill counts or an examination of prescription patterns demonstrate the possible overuse or selling of prescription narcotics? Each patient requires a thorough medical workup not only to ensure his or her medical stability, but also to ensure that his or her medical picture matches the history provided.

Collateral history, which can also be a great source of identifying historical inconsistencies, may be obtained from an individual's friends, family, or previous medical providers. Does a patient's spouse corroborate his or her history that he or she has not had any prior suicide attempts? Does a soldier's command provide a significantly different version of events ("No, that's not what happened, we found out the soldier gave

spice to another soldier and there was a large amount of it in his room when we searched it.")? When collecting this history from other individuals it is vital to ensure that the physician is not violating the patient's privacy or confidentiality laws. If a patient refuses to give permission to speak with other individuals, it still may be possible to collect collateral history from him or her, but great care must be taken to not share any patient information. Even the acknowledgment of any therapeutic relationship with a specific patient can be a violation of his or her confidentiality. A physician may also collect and share information with other members of the patient's medical team without violating the patient's confidentiality (eg, communication between inpatient and outpatient providers, and also gathering information from prior physicians).

Another source of external collateral may include military documentation. Does the individual's military records indicate previous deployments? Did the individual earn any deployment awards or purple hearts (an award given to soldiers who were injured by the enemy)? Are there any medical records down-range that document previous injuries? It is vital to remember that the lack of overseas medical records or deployment awards does not exclude a deployment history (especially if it occurred in the beginning of Operation Iraqi Freedom and Operation Enduring Freedom when theater medical records and deployment awards were not as established). If any doubt exists about the documentation's veracity, speak to the soldier about his or her deployed environments to get clarification. If a soldier cannot describe or converse about these places, it may indicate possible deception.

The *DSM-5* recommends considering malingering when a medico-legal context of presentation or a strong external motivator (such as financial gain) exists.³ This standard is difficult to apply in the military because every medical encounter, especially any encounter that describes a serious behavioral health condition, can be associated with significant long-term financial compensation. It is important to stay focused on the provider's role as clinician first and foremost, considering financial compensation only after other red flags present themselves as cause for concern. Financial gain is a form of secondary gain, and therefore still sometimes clinically relevant. It is mainly in cases where overt evidence indicates that the potential financial compensation is affecting the clinical picture (eg, overheard conversation about malingering for financial gain from the patient to another soldier) should financial gain affect a physician's assessment of the patient's reliability in the context of routine clinical encounters with soldiers and veterans.

CLINICAL MANAGEMENT

When a physician encounters several deception flags, it is prudent to obtain additional information. A good first step is to ask more open-ended questions and request more details about the patient's subsequent responses (Psychiatrist: "I heard you say that you are hearing a voice that is very distressing to you. Can you describe it more for me?" Patient: "What do you mean?" Psychiatrist: "What is the voice saying?" Patient: "Bad stuff." Psychiatrist: "What kind of stuff?" Patient: "Bad stuff that makes me want to hurt people." Psychiatrist: "Can you tell me exactly what the patient is saying?" Patient: "[noticeable pause] I just told you. Bad stuff."). Deception may be present if the patient is hesitant or unable to provide additional information, or becomes hostile when more open-ended questions are asked. Another source of information could be the patient's previous inpatient or outpatient medical records. If red flags are present, these records should be more thoroughly reviewed and inconsistencies should be noted.

In addition to more detailed history, observation and documentation of a patient's behavior when he or she is unaware of it is a critical component of a thorough assessment. Good opportunities to observe a patient include the waiting room of an outpatient clinic or the day room of an inpatient ward. Do patients who report extreme depression and appear dysphoric in an exam room maintain that affect or does their affect become more euthymic when they are reintroduced to the waiting room or the inpatient ward milieu? Is the limp that was present when the patient walked into the room still present when he or she walks down the hall away from the physician?

Furthermore, one can help clarify the presence of deception by asking about improbable psychiatric symptoms. Classic examples of this probing found in the literature are asking patients, "What kind of religion do cars have?" or "Do you hear voices when brushing your teeth?"⁶ Although these questions identify some intentional deception, some clinicians prefer to set up these more improbable psychiatric symptoms with a prior question. An example of this is to first ask the patient, "Are you left or right handed?" and then ask, "In that case, I assume you hear the voices more frequently from the left side of the room." Another possible example is to first ask if the patient has normal hearing or ask about certain aspects of his or her hearing, and then ask about the acoustic characteristic of the hallucinations.

Simple effort measures or intelligence testing in the interview is another tool that physicians can use after encountering red flags for deception. A simple in-office test to assess effort is to give patients a list of 10 words

and try to have them memorize them. Then give them a list of 20 words, 10 of which are the words they were already asked to memorize. Ask them to circle the 10 words they were previously given. If they have difficulty, instruct them to do their best to circle 10 words. Random chance alone indicates that individuals should have at least about half correct (even if they had not seen the previous list). If they have significantly less than half, there is a strong possibility that they are intentionally giving poor effort. One can calculate the probability of intentionally choosing wrong answers by a binomial probability analysis. Symptom exaggeration can occur with scores that are still above chance; but because this is not a standardized or researched psychological test, one cannot reliably distinguish poor effort in these marginal patients.

In a similar way, simple intelligence testing can also reveal deception. Many patients who deceive assume mental health patients (especially psychotic patients) have poor memory, attention, or intelligence. Asking simple questions such as "Who is the president of the United States?" "What is 2x4?" "What color is the sky?" and "How many nickels are equal to a quarter?" can sometimes help identify deception. Some truly psychotic patients with gross disorganization may have difficulty with focus, concentration, or abstraction, which are not only limited to the mini mental status exam or simple intelligence testing but also are consistently present throughout the interview.

Most importantly, a physician must remember the presence of a flag does not mean the individual is not being truthful. A recent study indicated that clinical providers can identify lies 64% of the time (only slightly higher than the 54% seen by the average adult). Providers described as "deception-interested" can only detect lies 71% of the time.^{9,10} Physicians need to acknowledge that their best clinical suspicions are possibly inaccurate.

Because of the possibility of an inaccurate clinical suspicion, if additional assessment continues to show possible malingering, objective measures should be considered. These tests vary widely but can include the SIMS (Structured Inventory of Malingered Symptomatology), the SIRS (Structured Interview of Reported Symptoms), and the F and F-K scales of the MMPI (Minnesota Multiphasic Personality Inventory)-2 among others. A psychologist who has experience with the measures must interpret these tests.

If significant evidence indicates that a patient is greatly over-exaggerating or feigning symptoms, physicians face a dilemma. Direct confrontation is normally not recommended. It is typically less effective,

and many patients “double down” or become more invested in their reported symptoms. Direct confrontation can also significantly damage the therapeutic rapport between the physician and the patient. An approach to consider is providing the patient an opportunity to save face while focusing on his or her care and treatment. A possible script follows:

I’ve found that many of my patients who are in a situation similar to yours are just trying to communicate how sick they are and how much help they need. My problem is that there is so much noise that you are reporting to me right now that is hard for

me to hear and focus on the issues you are most having problems with. I was wondering if you could do that for me.

Another technique described in the literature is to use a double-bind technique where a patient is informed that if the symptoms are real, the treatment should resolve them; but if they are not real, there is a greater chance they are factitious.^{11,12}

If deception is present, it is vital for physicians to examine their own countertransference toward the patient to ensure that they continue to provide quality objective assessments and high quality care.

DECEPTION AND THE MILITARY

There is a long history of deception and malingering in the military. The word malingerer itself, which reportedly appeared in a French dictionary in the 1800s, was defined as “a soldier who feigns sickness or induces or protracts an illness to avoid his duty.”¹²

Partially resulting from its deceptive nature, the frequency of malingering in the military is impossible to determine. Estimates range from “rare”¹³ to “a majority of claimants seeking disability compensation.”^{14,15} Rogers and Shuman’s *Conducting Insanity Evaluations* estimates the rate of malingering in the civilian population to be 1%, and it documents this rate could be five times higher in the military populations.¹⁶ The rates of malingering in the civilian population are thought to be much higher in cases involving legal issues (20%)^{12,16} or disability (between 30% and 40%).^{17,18} It is not known whether military disability cases have higher or lower levels of malingering than their civilian counterparts.

Regardless of the actual frequency of military malingering, it is known that malingering is significantly underdiagnosed in the military setting. Of the 28 million healthcare visits from 2006 to 2011 physicians diagnosed malingering in only more than a thousand cases (half of these were diagnosed by behavioral health clinics).¹⁹ This rate is much less than even the most conservative 1% malingering rate thought to be present in the civilian population. Similarly, between 1987 and 1995, the military had 49 court-martial cases for self-injury or feigning illness. Of those 49 cases, only 40 soldiers were convicted for these malingering charges.²⁰

It is the authors’ experience that deception is only occasionally encountered when working with the military population. This deception can potentially fall into three categories. The first and most frequently encountered deception in the military is the minimizing of symptoms, which is most often seen in aviators, special forces operators, intelligence analysts, or other members of other elite military units. These service members sometimes fear that if a physician learns of their symptoms, they will be prevented from doing their job that they typically enjoy. Minimization is also frequently seen throughout the military before deployments. Many soldiers minimize symptoms during their predeployment screenings to avoid the 90-day psychiatric stabilization period required before deployment, and then immediately seek behavioral healthcare once arriving in the country. Often these soldiers would rather try to temporarily deal with these symptoms on their own than risk the chance of not supporting the other team members when going to war. A second and opposite form of deception involves soldier’s magnifying or falsifying symptoms to avoid physical training, deployment, engaging with their chain of command, or another military responsibility. This type of deception is most commonly encountered in trainees or lower ranking service members. It is also possible that soldiers may exaggerate or create symptoms when engaging with the military disability system, but the rates of this occurring are not known.

RECENT CASE LAW

Military law is not dependent on medical terminology. UCMJ defines the rules of criminal law for US military members, and it applies to all five military uniformed services: (1) Army, (2) Marines, (3) Navy, (4) Air Force, and (5) Coast Guard. Article 115 of UCMJ defines malingering as:

Any person subject to this chapter who for the purpose of avoiding work, duty, or service—

- (1) feigns illness, physical disablement, mental lapse or derangement; or
- (2) intentionally inflicts self-injury; shall be punished as a court-martial may direct.²¹

The *Manual for Courts-Martial* elaborates further on this, as follows:

Elements.

- (1) That the accused was assigned to, or was aware of prospective assignment to, or availability for, the performance of work, duty, or service;
- (2) That the accused feigned illness, physical disablement, mental lapse or derangement, or intentionally inflicted injury upon himself or herself; and
- (3) That the accused's purpose or intent in doing so was to avoid the work, duty, or service. [Note: If the offense was committed in time of war or in a hostile fire pay zone, add the following element]
- (4) That the offense was committed (in time of war) (in a hostile fire pay zone).

Explanation.

(1) Nature of offense. The essence of this offense is the design to avoid performance of any work, duty, or service which may properly or normally be expected of one in the military service. Whether to avoid all duty, or only a particular job, it is the purpose to shirk which characterizes the offense. Hence, the nature or permanency of a self-inflicted injury is not material on the question of guilt, nor is the seriousness of a physical or mental disability, which is a sham. Evidence of the extent of the self-inflicted injury or feigned disability may, however, be relevant as a factor indicating the presence or absence of the purpose.²²

Many frustrated behavioral health providers will say that despite the relatively straightforward nature of the legal descriptions above, they have been discouraged by their Judge Advocates General from recommending that the command pursue this charge because of the difficult burden of proof and poor success rate of cases prosecuted. Often successful prosecutions are ultimately charged under a subset of Article 134 that describes self-injury, instead. It states:

Elements.

- (1) That the accused intentionally inflicted injury upon himself or herself;
- (2) That, under the circumstances, the conduct of the accused was to the prejudice of good order and discipline in the armed forces or was of a nature to bring discredit upon the armed forces. [Note: If the offense was committed in time of war or in a hostile fire pay zone, add the following element]
- (3) That the offense was committed (in time of war) (in a hostile fire pay zone).²³

Explanation.

Nature of offense. This offense differs from malingering in that for this offense, the accused need not have harbored a design to avoid performance of any work, duty, or service which may properly or normally be expected of one in the military service. This offense is characterized by intentional self-injury under such circumstances as prejudice good order and discipline or discredit the armed forces. It is not required that the accused be unable to perform duties, or that the accused actually be absent from his or her place of duty as a result of the injury. For example, the accused may inflict the injury while on leave or pass. The circumstances and extent of injury, however, are relevant to a determination that the accused's conduct was prejudicial to good order and discipline, or service discrediting.²²

Despite the difficult nature of prosecuting malingering under UCMJ, it does continue to be done successfully. As each additional case is adjudicated, new case law can be used to inform future decisions. Below are some examples of case law that were successfully prosecuted under Article 115 as well as some that were also prosecuted for self-injury in prejudice to good order and discipline under Article 134:

In *United States v Tyson*, the court found the defendant guilty of malingering. The finding states that he "did, at or near Fort Polk, Louisiana, on or about 8 May 2011, for the purpose of avoiding his duty to return to his unit in Afghanistan, a deployed environment, intentionally injure himself by discharging a .40 caliber pistol round through the palm of his right hand," in violation of Article 134 and Article 115.²⁴

In *United States v Wegley*, a service member was convicted of soliciting a trainee to shoot the service member in the leg. The conviction was challenged, and the Article 115 charge stood, but the Article 134 charge was dropped, since the court felt that the prosecution failed to prove that the conduct was prejudicial to good order and discipline or was service discrediting, either expressly or by necessary implication, and the trial record did not provide notice to the service member of the terminal element.²⁵

In *United States v Abbey*, the defendant admitted to altering a sick slip with the intent to avoid physical training, and to aid her discharge from the Army. She further admitted her conduct was prejudicial to good order and discipline, and it met the standard for 134 and a malingering charge under Article 115.²⁶

SUMMARY

Where is the line between medical and legal in the case of malingering? Deception is a potential problem in any clinical encounter, yet some may deceive for

reasons other than malicious or fraudulent intent. It is important to consider this when faced with a patient one suspects of malingering, not only because of the

impact it may have on him or her, but also because malingering has additional meaning in a military setting. Military behavioral health providers have a dual obligation to both protect their patients and act in the best interest of the military and government. When presented with a service member who appears to be feigning illness, many things must be considered before making a diagnosis. Using objective data and identifying red flags can be used to enhance one's understanding of the clinical picture, and choosing an approach in any given encounter can assist with obtaining an appropriate level of rapport versus objective data gathering. However, even if the diagnosis of malingering is given, no legal recourses are available to the behavioral health provider, and it is the commander's decision whether to pursue UCMJ prosecution.

Although some similarities exist, the UCMJ and the DSM have different standards on defining a malingerer. The case law on this issue continues to evolve, and how the military manages malingering is ever changing, especially since each military conflict continues to provide new challenges for the military medical and justice systems. The presence of malingering or factitious disorders significantly affects patient care because patients can potentially mask significant underlying psychiatric conditions or if unresolved, patients may create extremely dysfunctional patterns from their attempts to adequately portray specific clinical conditions. Malingering or factitious disorder can also lead to the treatment of feigned symptoms with medications or treatments that carry their own risks. By appropriately addressing these issues, physicians act in the soldier's best interest.

ACKNOWLEDGMENTS

The authors would like to thank Lieutenant Colonel Christopher Lange, Medical Corps, US Army, for his mentorship and credit him with many of the ideas presented here, particularly in the subsection titled Clinical Approaches. In addition, the authors would like to thank Major Eric Allen, Judge Advocate, US Army Reserve, for assisting with the legal review and providing recent case law. Lastly, we would like to thank Colonel (Retired) Elspeth Ritchie for giving the authors the opportunity to contribute to this project.

REFERENCES

1. Kohut H. *The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders*. Chicago, IL: University of Chicago Press, 2000.
2. Harvey AG, Tang NK. (Mis)perception of sleep in insomnia: a puzzle and a resolution. *Psychol Bull*. 2012;138:77–101.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Publishing; 2013:309–327, 726–727.
4. Rosenhan DL. On being sane in insane places. In: Henslin JA, ed. *Down to Earth Sociology: Introductory Readings*. 11th ed. New York, NY: Free Press; 2001:278–289.
5. Goodwin DW, Alderson P, Rosenthal R. Clinical significance of hallucinations in psychiatric disorders: a study of 116 hallucinatory patients. *Arch Gen Psychiatry*. 1971;24:76–80.
6. Resnick PJ. Malingered psychosis. In: Rogers R, ed. *Clinical Assessment of Malingering and Deception*. 2nd ed. New York, NY: Guilford Press; 1997:47–67.
7. Gurriel J, Fremouw W. Assessing malingered posttraumatic stress disorder: a critical review. *Clin Psychol Rev*. 2003;23:881–904.
8. Hall RC, Hall RC. Malingering of PTSD: forensic and diagnostic considerations, characteristics of malingerers and clinical presentations. *Gen Hosp Psychiatry*. 2006;28:525–535.
9. Meyer P. *Liespotting: Proven Techniques to Detect Deception*. New York, NY: Macmillan; 2010: Kindle locations 240–242.
10. Ekman P, O'Sullivan M, Frank MG. A few can catch a liar. *Psychological Science*. 1999;10:263–266.

11. Eisendrath SJ. Factitious physical disorders: treatment without confrontation. *Psychosomatics*. 1989;30:383–387.
12. Sadock BJ, Sadock VA, Ruis P, Kaplan HI, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. 9th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2009: 2480.
13. Office of The Surgeon General/Medical Command. *Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder (PTSD)*. April 10, 2012. OTSG/MEDCOM Policy Memo 12-035.
14. Frueh BC, Grubaugh AL, Elhai JD, Buckley TC. US Department of Veterans Affairs disability policies for posttraumatic stress disorder: administrative trends and implications for treatment, rehabilitation, and research. *Am J Public Health*. 2007;97:2143–2145.
15. McNally RJ, Frueh BC. Why are Iraq and Afghanistan War veterans seeking PTSD disability compensation at unprecedented rates? *J Anxiety Disord*. 2013;27:520–526.
16. Rogers R, Shuman DW. *Conducting Insanity Evaluations*. 2nd ed. New York, NY: Guilford, 2000.
17. Bass C, Halligan PW. Illness related deception: social or psychiatric problem? *J R Soc Med*. 2007;100:81–84.
18. Mittenberg W, Patton C, Canyock EM, Condit DC. Base rates of malingering and symptom exaggeration. *J Clin Exp Neuropsychol*. 2002;24:1094–1102.
19. Lande RG, Williams LB. Prevalence and characteristics of military malingering. *Mil Med*. 2013;178:50–54.
20. Ritchie C. Malingering and the United States military. In: Lande RG, ed. *Principles and Practice of Military Forensic Psychiatry*. Springfield, IL: Charles C Thomas; 1997:129–130.
21. Article 115. Malingering, US Code Service. 10 USCS § 915, Title 10. Armed Forces, Subtitle A. General Military Law, Part II. Personnel, Chapter 47. Uniform Code of Military Justice, Subchapter X. Punitive Articles, § 915.
22. *Manual for Courts-Martial United States (2012 Edition)*. Washington, DC: US Department of Defense; 2012: IV-59, 40, IV-129, 104.
23. Article 134. General Article, US Code Service. 10 USCS § 915, Title 10. Armed Forces, Subtitle A. General Military Law, Part II. Personnel, Chapter 47. Uniform Code of Military Justice, Subchapter X. Punitive Articles, § 934.
24. *United States v Tyson*, CCA LEXIS 283 (2012).
25. *United States v Wegley*, CCA LEXIS 423 (2012).
26. *United States v Abbey*, 63 MJ 631 (2006).

